

Characteristics of Sheltered Homeless Families

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Abstract: To describe the characteristics of homeless families, we interviewed 80 homeless mothers and 151 children living in 14 family shelters in Massachusetts (two-thirds of the shelters in the state). Ninety-four per cent of the families were headed by women, 91 per cent were on AFDC (aid to families with dependent children), with twice as many as the state average having been on AFDC for at least two years; most had long histories of residential instability. Although 60 per cent had completed high school, only a third had worked for longer than one month. One-third of the mothers reported having been abused during their childhood, and two-thirds had experienced a major family disruption. At the time of the interview, almost two-thirds either lacked or had minimal supportive relationships and one-fourth of these named their child as the major support.

Eighteen mothers were involved with the Department of Social Services because of probable child abuse or neglect. Seventy-one per cent of the mothers had personality disorders. In contrast to many adult homeless individuals, however, deinstitutionalized persons or those suffering from psychoses were not overrepresented. About 50 percent of the homeless children were found to have developmental lags, anxiety, depression, and learning difficulties, and about half required further psychiatric evaluation. Two-thirds described housing and social welfare agencies as not helpful. Given the many serious problems of the mothers and the difficulties already manifested by their children, comprehensive psychosocial and economic interventions must be made to interrupt a cycle of extreme instability and family breakdown. (*Am J Public Health* 1986; 76:1097-1101.)

Introduction

While homelessness has long been a problem for individuals, many cities describe a recent problem with homeless families. New York City, for example, is attempting to shelter approximately 4,000 families (14,530 individuals including 9,590 children).¹ On any given night in Massachusetts, 200 families reside in shelters (including individual, family and specialized facilities) and the overflow of 380 to 550 are placed in welfare hotels or motels.² It is estimated that across the country family members now comprise more than 20 per cent of the overall homeless population and that their numbers will double in 1986.³

Despite the far-reaching social consequences of family homelessness, descriptions of this subgroup are sparse. New York City reports unmet nutritional needs,⁴ inadequate service delivery,⁵ substandard conditions in the sheltering facilities,⁶ and severe emotional problems in the families.^{5,7,8} An anecdotal study indicates developmental delays in the children,^{*} but systematic clinical data are lacking. The present report provides systematically collected descriptive clinical information about homeless families sheltered in Massachusetts.

Methods

Subjects

Eligible subjects were all members of homeless families residing in family shelters in Massachusetts during the period from April to July, 1985. Battered women's shelters, facilities serving specialized populations (e.g., teenage mothers), and those housing fewer than three families were not eligible. A family was defined as at least one parent with one child, or a pregnant mother.

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We were able to arrange access to six of eight family shelters in Boston and to eight of 13 outside the city (Attleboro, Brockton, Holyoke, Hyannis, Lowell, Northampton, Springfield, and Worcester). We interviewed members of 82 families with 156 children out of a possible 101 families and 160 children. We excluded one family headed by a single man, and one headed by a married couple because the mother was unable to participate. This left 80 families with 151 children (49 of the families with 90 children were from Boston). Seventy-five families were headed by women and the remaining five by married couples; the latter group did not differ from their single counterparts except on ethnicity, marital status, and history of independent living. The non-participating families were similar to the participants in terms of parental gender, age, ethnicity, behavior, length of stay at the shelter, and the children's age, gender, and number per family.

Representativeness of the Sample

We were unable to arrange access to one-third of the family shelters in Massachusetts. Various shelter directors expressed concern that a study would further dehumanize and perhaps even victimize their clients. Data provided by the seven non-participating shelters suggest that their guests were similar to those in the study in terms of family composition, age, marital status, number of children, and length of stay. The sample may underrepresent Latinos since we were unable to arrange access to one shelter that primarily houses Latino families. With this exception, the sample studied appears to be reasonably representative of families living in Massachusetts family shelters.

It is possible that homeless families with serious behavioral or emotional problems are underrepresented in these shelters. In Massachusetts, homeless families are generally referred directly to family shelters. The staff turns away approximately 10 to 15 families at the larger shelters each week, two to three at the smaller shelters. Those exhibiting alcoholism, drug abuse problems, and major mental illness tend to be the first to be excluded. Some of the overflow is housed in welfare hotels and motels. What happens to the remainder is unknown.

Interviews

Psychiatrists and a child psychologist (Spanish-speaking when indicated) completed the interviews. Written informed consent to interview all members of the family unit was

obtained from each parent. In the early phase of the study, we often had to reschedule many interviews with the same family; to increase compliance, we offered monetary incentives to participants in the latter part of the study.

Parents—A semi-structured clinical interview consisting of approximately 260 items was administered to each parent. Questioning focused on: demographics; developmental background including early relationships with caretakers; family disruptions and patterns of violence; topics related to adult functioning such as housing, income and work histories, nature of relationships, health status; and patterns and perceptions of service delivery. In addition, a structured questionnaire, the modified Social Support Network Inventory⁹ was administered, and psychiatric diagnoses were made using DSM-III¹⁰ inclusion and exclusion criteria.

Children—With the interviewer's guidance, each parent completed a standardized validated behavioral checklist describing her child's behavior: The Simmons Behavior Checklist¹¹ was used for children between the ages of 3 and 5 years, and the Achenbach Behavioral Problem Checklist¹² for children older than 5.

The interviewer played with and/or talked to each child before administering standardized instruments. The Denver Developmental Screening Test¹³ was used to assess children 5 years of age or younger while the Children's Depression Inventory¹⁴ and the Children's Manifest Anxiety Scale¹⁵ were administered to older children.

Results

The Mothers

Characteristics—The median age of the homeless mothers was 27 years (Table 1), with a range from 17 to 49 years. Only six mothers were younger than 20 years. Although the overall percentages of White and Black families were approximately equal, almost two-thirds of Boston mothers were Black, while three-fourths of non-Boston mothers were White. Forty-five per cent of the women were single mothers; and 45 per cent were divorced, separated, or widowed. The proportion of single mothers within the Boston shelters (57 per cent) was higher than the proportion outside of Boston (26 per cent).

About 60 per cent of the sheltered mothers had at least a high school education (Table 1). The mothers had an average of 2.4 children, and an average of 2 were living with them in the shelter. The median age of the mother at the birth of her first child was 19 years, with a range of 14 to 37 years; approximately one-fourth had their first child at the age of 17 years or less; 11 were pregnant at the time of the interview.

Employment—About a third of the mothers reported having held a job for longer than one month (Table 1). Seven mothers were working part time during the interviewing period.

Incarceration—Ten women had been in jail for offenses ranging from larceny to prostitution, of which half were drug-related.

Relationships—About one-fourth of the mothers were unable to name any supports and 18 per cent could only name one person (Table 1). In the latter group, many mentioned a recent shelter friend or professional contact and over one-fourth named their child. Eighteen mothers were involved in an investigation or follow-up of child abuse and neglect.

When asked about relationships with men, 58 per cent reported a history of one major relationship with a man, 32 per cent described two or three, and 10 per cent described none. The men with whom they had the most recent rela-

TABLE 1—Characteristics of Homeless Mothers Residing in Massachusetts Family Shelters (N = 80)

Characteristics	Per Cent	N
Age (median)		
27 years		
Geographic Area		
Boston	61	49
Other	39	31
Ethnicity		
White	48	38
Black	45	36
Latino	6	5
Other	1	1
Marital Status		
Single	45	36
Married	10	8
Separated, Divorced, Widowed	45	36
Education		
Partial High School	41	32
HS Grad/GED	37	29
Some College	22	17
Employment History		
Some Work Experience	36	29
Occasional	23	18
Minimal or Never Worked	41	33
Number of Supports		
None	26	21
One	18	14
Two	20	16
Three or More	36	29
Health Status*		
Current Contact with Mental Health System	24	19
Alcohol Problem	8	6
Drug Problem	9	7
Physical Illness	21	17

*Categories are not mutually exclusive and only those with a reported problem are included.

tionship generally were said to have poor work histories, substance abuse problems, and battering tendencies. Twenty-nine women had been involved in at least one relationship in which they had been battered; more than two-thirds of the reported violence was alcohol or drug-related.

Health/Mental Health Status—Overall, 44 women had contact with the mental health system at some point in their lives, and 19 had been involved during the previous year (Table 1). Six had histories of psychiatric hospitalization; seven had substance abuse problems, two of whom were receiving treatment. Seventeen described a major physical illness or ailment requiring ongoing medical attention.

One-fourth of the mothers were assigned DSM-III Axis-I diagnoses indicating the presence of major psychiatric clinical syndromes (Table 2). Fifty-seven (71 per cent) were given Axis-II diagnoses of personality disorders. There were nine mothers with both Axis-I and II diagnoses. Only 11 mothers had no DSM-III diagnosis.

Early Family Disruptions—A third of the homeless mothers had never known their fathers. More than two-thirds described at least one major family disruption during childhood (almost half were due to separation or divorce of the parents; the remainder were due to the death of a parent, mental illness and alcoholism of the parent, abuse resulting in state placement, and miscellaneous reasons). Twenty-one of the 52 disruptions occurred when the mother was 5 years old or younger; in about half the disruptions, the child remained with one parent, but 12 were placed with a relative, eight ran away, four were put in foster care, and three were admitted to mental hospitals. One-third of the homeless mothers

TABLE 2—DSM-III Psychiatric Diagnoses of Massachusetts Sheltered Homeless Mothers (N = 80)

Psychiatric Diagnoses	Per Cent	N
<i>Axis I—Clinical Syndromes</i>		
Total Present	27	21
Major Affective Disorders	10	8
Substance Abuse	9	7
Mental Retardation	5	4
Schizophrenia	3	2
Total Absent	73	59
<i>Axis II—Personality Disorders</i>		
Total Present	71	57
Dependent	24	19
Other	13	10
Atypical	10	8
Borderline	6	5
Narcissistic	4	3
Antisocial	4	3
Passive-aggressive	4	3
Mixed	4	3
Schizoid	3	2
Histrionic	1	1
Total Absent	29	23

reported that they had been physically abused, generally by their mothers. Nine acknowledged that they had been sexually abused.

Income Maintenance/Housing History—Ninety-one per cent of the families were receiving aid to families with dependent children (AFDC). Although only 30 per cent of Massachusetts AFDC recipients¹⁶ had been receiving AFDC for more than two years, 59 per cent of shelter mothers (95% confidence limits 48 per cent, 70 per cent) had been AFDC recipients for at least this long. Forty-seven families were getting food stamps, 25 were receiving WIC (women, infants and children supplemental program), and 20 had housing subsidies.

Overall, the families had moved an average of 6.6 times (range 2 to 24) in the five years prior to the current homelessness episode, and 3.6 times (range one to 11) in the year before becoming homeless. During the previous five years, 85 per cent had been doubled up and more than 50 per cent had been in other emergency housing facilities. One-third had been in two or more of these situations, while one-fifth were in three or more. More than 40 per cent had come to the shelters from shared, but overcrowded living arrangements. When asked why they had lost their home, 57 per cent cited such problems as eviction, nonpayment of rent, condominium conversion, and, most commonly, overcrowding. Almost one-third described an interpersonal precipitant: dissolution of a relationship with a man, battering, death or illness within the mother's nuclear family, or inability to get along with others in a shared domestic arrangement (excluding overcrowding).

Most mothers tended to move within the area where they grew up and to be sheltered in emergency facilities in that community. The length of stay in the shelters averaged two to three months.

The Children

The 151 children ranged in age from 6 weeks to 18 years. Two-thirds were 5 years or younger. The numbers of boys and girls were about equal.

Testing—Based on the Denver Developmental Screening test, 47 per cent of 81 children aged 5 years or younger had at least one developmental lag and 33 per cent had two or

TABLE 3—Clinical Characteristics of Massachusetts Sheltered Homeless Children

Clinical Characteristics	Per Cent
<i>Children 5 years or younger (N = 81)</i>	
Denver Developmental Screening Test	
Number of Developmental Lags	
None	53
1	14
2	17
3	3
4	14
Skills Affected	
Language acquisition	37
Personal and social growth	34
Gross motor skills	18
Fine motor coordination	15
<i>Children Older than Five</i>	
Children's Depression Inventory (N = 44)	
Requires psychiatric evaluation (cutoff = 9)	54
Evidence of clinical depression (cutoff = 13)	31
Children's Manifest Anxiety Scale (N = 50)	
Requires psychiatric evaluation (Scored higher than mean of 14.4; standard deviation = 6.2)	48

more lags (Table 3). Using the Simmons Behavior Checklist, 55 children ages 3 to 5 years scored higher than the overall mean of 5.6 on the following factors: shyness (9.6), dependent behavior (7.4), aggression (7.4), attention span (7.3), withdrawal (6.1), and demanding behavior (5.7). They scored less than the mean on sleep problems (4.5), coordination (4.1), fear of new things (3.8), and speech difficulties (3.5) [data not shown; available on request to author].

The findings on the Children's Depression Inventory and the Children's Manifest Anxiety Scale suggested that, among the 52 children over age 5 tested, approximately half required further psychiatric evaluation. Based on the Achenbach parent checklist, among the 29 6–11 year olds tested, two-thirds of the boys and almost one-half of the girls required further psychiatric evaluation; in the 13 children in the 12–16 year group, more than one-third required psychiatric referral [data not shown; available on request to author].

School Problems—While all school age children were reported by their parents to be attending school, shelter directors indicated that attendance was irregular. According to reports from parents, 21 children were failing or performing below average work; 25 per cent were in special classes; and 43 per cent had already repeated one grade.

Medical, Emotional Problems—Based on parental reports, 12 children had medical problems requiring ongoing care by a physician. However, about one-fourth of the children were described by parents as having an emotional or developmental problem.

Service Utilization

Thirty-four mothers reported current involvement with a social welfare or housing agency while they were living in the shelter. Such involvement was defined as at least one contact (including by telephone) with a service provider during their shelter stay. Likelihood of involvement increased in proportion to the length of stay. For example, of 40 families at the shelter one month or less, 30 per cent were involved, whereas 85 per cent of 14 families sheltered longer than three months were receiving some type of social services.

Thirty-four families described some involvement (past

or present) with the Department of Social Services: more than half had open 51As (obligatory contacts for child abuse); 26 contacts with housing authorities; 70 contacts with the Department of Public Welfare; and six with the Department of Mental Health. However, two-thirds described their contact with these agencies as "not at all helpful" (scores of 1 or 2 on a 7-point rating scale). In contrast to their perception of these public agencies, two-thirds of the mothers described their shelter experience as quite helpful, and only eight scored it "not at all helpful."

Nearly half of the women could name a family doctor or hospital from which they had received "helpful" or "very helpful" treatment within the previous year. Only one child had not received his inoculations.

Despite the children's emotional and developmental difficulties, however, only 14 of the children 5 years of age and younger were in day care, and only 12 of all the children were in therapy/counseling.

Discussion

Our data indicate that many of the women heading these homeless families now have difficulty establishing themselves as autonomous adults. Although many have completed high school, they are unable to hold jobs, and generally lack or have limited relationships with other adults or institutions although they have lived in the same community most of their lives. Many were unable to maintain a home because of economic and interpersonal problems and most had long histories of residential instability. This subgroup is most likely to become long-term AFDC recipients¹⁷ and, with the current low-income housing crisis, part of the permanent "underclass" population.¹⁸

In contrast to many adult individual homeless persons who have been deinstitutionalized and suffer from psychoses such as schizophrenia,^{19,20} psychoses were not over-represented among homeless mothers. Overall, about one-fourth suffered from a major psychiatric clinical syndrome (i.e., DSM III, Axis-I), but these did not cluster into a single category.

Seventy-one per cent of homeless mothers were assigned Axis-II diagnoses of personality disorders. In contrast, large-scale random sampling estimates of the prevalence of serious personality disorders in the adult population range from 5-15 per cent.^{21,22} Although specific criteria exist for each diagnosis, personality disorders are less reliable and valid than Axis-I diagnoses.^{23,24} Moreover, personality disorder is a diagnosis of social dysfunction and does not take into account the influence of environmental factors extrinsic to the organization of the personality, such as poverty, racism, and gender-bias.²⁵ Criteria for these disorders are no more than descriptions of behavioral disturbances that are long-term and predate the homelessness episode. The resultant diagnostic labeling may exaggerate the degree of psychopathology within this subgroup of homeless women. Thus, the labels should primarily be used to indicate severe functional impairment and the need for help rather than implying strict causality.

Given the mother's pervasive emotional problems and the conditions in the sheltering facilities, it is not surprising that approximately 50 per cent of the homeless children interviewed required further psychiatric and medical evaluation.

There is a belief that family homelessness has been caused exclusively by external factors such as the shortage of low-income housing, the inadequacy of AFDC benefits, and

the breakdown of family structure in association with poverty.²⁶ Our data suggest that psychosocial factors, particularly family breakdown, play an important role as well. There can be little doubt that the constellation of economics, subsistence-living, family breakdown, psychological deprivation, and impoverished self-esteem contribute to the downward cycle of poverty, disruption, stress, and violence. With the unavailability of affordable housing, the most emotionally vulnerable and marginal members of society will be the first to fall through the "safety net." The homeless families of the 1980s may well be the "multi-problem" families of previous decades,²⁷ but they are now far more visible. We must also ask whether these children are likely to become the system dependent and perhaps the homeless adults of the next generation.

Although identifying and labeling emotional problems among a disadvantaged population always carries with it the risk of "blaming the victim,"²⁸ ignoring psychological factors will lead to faulty social planning. If family homelessness were due solely to economics and bad luck, then the potential solution would involve only income assurance and the construction of many more low-income housing units. However, if the problem has both economic and psychological roots, then support and rehabilitative services attached to specialized housing alternatives become an essential part of the solution.

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NIH: Health Implications of Smokeless Tobacco Use

"Use of smokeless tobacco has a long history in the United States, but trends in recent years, in particular the increasing use of snuff by children and young adults, have led to concerns about possible health consequences.

"National data suggest that at least 10 million persons have used smokeless tobacco of one kind or another within the past year. Patterns of use by age and sex appear to be similar across the country.

"The human evidence that use of snuff causes cancer of the mouth is strong. Risk is particularly high for parts of the mouth where the snuff is usually placed. Data are currently insufficient to come to any conclusions regarding the relationship of smokeless tobacco use to cancers at other sites. Repeated experimental studies in animals have failed to provide adequate evidence that chewing tobacco, snuff, or extracts derived from them induce cancer. However, nitrosamines chemically related to nicotine occur at high levels in snuff and, generally, at lower levels in chewing tobacco. These compounds are highly carcinogenic in animals. The concentrations of nitrosamines in smokeless tobacco are far higher than the levels of these compounds allowed in any U.S. food or beverage.

"Smokeless tobacco use increases the frequency of localized gum recession and leukoplakia where the snuff is usually placed, but evidence on its relationship to other diseases of the oral cavity is inadequate. The presence of lead in smokeless tobacco may pose a special risk for the developing fetus.

"Use of smokeless tobacco releases nicotine into the bloodstream and produces blood levels of nicotine comparable to those produced by smoking tobacco. The primary behavioral consequence of regular use of smokeless tobacco is long-term nicotine dependence and its associated health risks.

"Use of smokeless tobacco is one of a number of health-endangering behaviors which frequently coincide, raising the clear potential for long-term and serious consequences."

The preceding excerpt is from the National Institutes of Health Consensus Development Conference Statement on "Health Implications of Smokeless Tobacco Use," resulting from the consensus development conference convened January 13-15, 1986. The full consensus statement is available from US Department of Health and Human Services, NIH, Office of Medical Applications of Research, Building 1, Room 316, Bethesda, MD 20892.